MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00415 305

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:

COUNTY Charles — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Waldorf

LENGTH OF STAY (in this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Charles

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Waldorf

STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) M. (Last) Adams

4. DATE OF DEATH: (Month) 1 (Day) 4 (Year) 19 53

5. SEX: M.

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): S.

8. DATE OF BIRTH: 9-14-1872

9. AGE last birthday: 80 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant

10b. KIND OF BUSINESS OR INDUSTRY: own store

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME: Hugh Adams

14. MOTHER'S MAIDEN NAME: Elizabeth Adams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: Edward Newman, friend

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

331.1

Immediate cause (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1-2-53

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

DUE TO (b) Hypertension — ?

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-1-53, to ....., 19....., that I last saw the deceased alive on ....., 19....., and that death occurred at .....m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) M.D. ADDRESS La Plata Md DATE SIGNED 1-5-53

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF 1-7-53

NAME OF CEMETERY OR CREMATORY St. Paul's

LOCATION (City, town, or county) (State) Waldorf

DATE REC'D BY LOCAL REG. 1-7-53

REGISTRAR'S SIGNATURE W. L. Monroe

24. FUNERAL DIRECTOR Hunt & Ryon, Waldorf, Md ADDRESS

RECEIVED
JAN 8
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00416

CERTIFICATE OF DEATH

Reg. Dist. No. 100

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Charles — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: La Plata
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Physicians Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY St. Marys
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mechanicsville
STREET ADDRESS (If rural, give location): ✓

3. NAME OF DECEASED: (First) Alfred (Middle) Cully (Last) Boswell
4. DATE OF DEATH: (Month) January (Day) 6, (Year) 1953
5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Feb. 25, 1910
9. AGE last birthday: 42 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fireman, Stationery, U. S. Civil Service
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME: Alfred Boswell
14. MOTHER'S MAIDEN NAME: Carrie Cully
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: Frances Boswell, (wife) Mechanicsville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Acute Coronary Thrombosis — DUE TO — Interval Between Onset and Death: 5 hours.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b) — DUE TO
(c)

420

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: —
(CITY OR TOWN) — (COUNTY) — (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY: — — — M.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from September, 1950., to January 6, 1953., that I last saw the deceased alive on January 6, 1953., and that death occurred at 11:45 P.M., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS — DATE SIGNED
John N. Griffin, M.D. Hughesville, Md. 1/7/53

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: 10-10-53
NAME OF CEMETERY OR CREMATORY: Arbutus Memorial Park
LOCATION (City, town, or county) (State): Arbutus, Md.

DATE REC'D BY LOCAL REG. 1/7/53
REGISTRAR'S SIGNATURE: Julia H Posey
24. FUNERAL DIRECTOR: Joseph L. Russ Funeral Home
ADDRESS: 2222 West North Ave., Baltimore, Md.

RECEIVED
JAN 9 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00417

CERTIFICATE OF DEATH

Reg. Dist. No. 100

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY CHARLES; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HUGHESVILLE
LENGTH OF STAY (In this place) LIFE
HOSPITAL OR INSTITUTION OR STREET ADDRESS RURAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY CHARLES
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HUGHESVILLE
STREET ADDRESS (If rural, give location) RURAL

3. NAME OF DECEASED (Type or Print): (First) MARY (Middle) MAGDALENE (Last) BROWN

4. DATE OF DEATH: (Month) JANUARY (Day) 4 (Year) 1953

5. SEX: FEMALE

6. COLOR OR RACE: NEGRO-U.S.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: MARCH 25 1883

9. AGE last birthday: 69 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: DOMINIC WADE

14. MOTHER'S MAIDEN NAME: MELINDA COATES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If year, give war or dates of service): —

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT AND ADDRESS: JAMES ALBERT BROWN: HUGHESVILLE MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) CEREBRAL HEMORRHAGE, RIGHT — Interval between onset and death: 30 HOURS.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) GENERALIZED ARTERIO-SCLEROSIS WITH HYPERTENSION — 10 YEARS.

(c) DIABETES MELLITUS — 7 YEARS

331 (260)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): —

(CITY OR TOWN): — (COUNTY): — (STATE): —

TIME OF INJURY (Month) (Day) (Year) (Hour): — m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from SEPTEMBER 1947., to JANUARY 4., 1953., that I last saw the deceased alive on JANUARY 3., 1953., and that death occurred at 1 30 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): John N. Griffin, M.D. ADDRESS: Hughesville, Md. DATE SIGNED: 1/5/53

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE: 1-7-53 | NAME OF CEMETERY OR CREMATORY: St Mary's | LOCATION (City, town, or county) (State): Bryantown Md

DATE REC'D BY LOCAL REG.: 1/6/53 | REGISTRAR'S SIGNATURE: Julia H. Posey | 24. FUNERAL DIRECTOR ADDRESS: Hunt & Ryon, Waldorf Md.

RECEIVED
JAN 8 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00418

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:
COUNTY Charles MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bel Alton Md
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bel Alton
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) Samuel (Last) Combs

4. DATE OF DEATH: (Month) 1 (Day) 23 (Year) 1953

5. SEX: M
6. COLOR OR RACE: C
7. SINGLE, ~~MARRIED, WIDOWED, DIVORCED~~, (Specify):
8. DATE OF BIRTH: Mch 2 - 1880
9. AGE last birthday: 72 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labour
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): St Marys Co Md
12. CITIZEN OF WHAT COUNTRY: NS

13. FATHER'S NAME: Alex Combs
14. MOTHER'S MAIDEN NAME: Mary Hyde

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No
16. SOCIAL SECURITY NO.: No
17. INFORMANT & ADDRESS: Annie Brown Sister

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myocarditis
DUE TO

Antecedent cause(s) (b)
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
DUE TO
(c)

422.2

II. OTHER SIGNIFICANT CONDITIONS:
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION: None
19b. MAJOR FINDINGS OF OPERATION: None
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) M.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 18, 1953, to Jan 23, 1953, that I last saw the deceased alive on Jan. 23, 1953, and that death occurred at 4:01 a.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED
Ernest [illegible] Jan 23 1953

23. BURIAL, ~~CREMATION REMOVAL~~ (Specify): DATE THEREOF 1-26-53 NAME OF CEMETERY OR CREMATORY St Ignatious LOCATION (City, town, or county) Bel Alton (State) Md

DATE REC'D BY LOCAL REG. 1/26/53 REGISTRAR'S SIGNATURE Julia H Pasey
24. FUNERAL DIRECTOR Hunt A & Bros ADDRESS Waldorf Md

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1

RECEIVED
JAN 28 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00419

CERTIFICATE OF DEATH

Reg. Dist. No. 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Charles. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN La Plata.
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Physicians Memorial Hospital.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Spring Hill Md
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) D (Last) COOKSEY

4. DATE OF DEATH: (Month) January (Day) 10 (Year) 1953.

5. SEX: Male

6. COLOR OR RACE: White.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W.

8. DATE OF BIRTH: Oct. 21, 1874

9. AGE last birthday: 78 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (State or foreign country): Charles Co Md

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: James C. Cooksey

14. MOTHER'S MAIDEN NAME: Susie E. Cook

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO.: No

17. INFORMANT & ADDRESS: Wilmer Cooksey Son

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1

Immediate cause (a) Coronary occlusion. — Interval between onset and death: 2 hours

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) Senile arteriosclerosis with hypertension. — 10 years.

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 19 49, to 10 Jan., 19 53, that I last saw the deceased alive on 10 Jan, 19 53, and that death occurred at 11:58 ? m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) MD ADDRESS La Plata. Md. DATE SIGNED 10 Jan 53.

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify): DATE THEREOF Jan 13-53 NAME OF CEMETERY OR CREMATORY Trinity LOCATION (City, town or county) (State) New Port Md

DATE REC'D BY LOCAL REG. 1/12/53 REGISTRAR'S SIGNATURE Julia H. Casey

24. FUNERAL DIRECTOR Hunt & Gardner Waldorf Md ADDRESS

RECEIVED
JAN 14 1953
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1120

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:
COUNTY Charles — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Hughesville
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Hughesville
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED: (First) George (Middle) Mathews (Last) Curtis

4. DATE OF DEATH: (Month) JAN (Day) 29 (Year) 19 53

5. SEX: M

6. COLOR OR RACE: N

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: July 22 1913

9. AGE last birthday: 39 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tenant

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): St. Marys County, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Curtis

14. MOTHER'S MAIDEN NAME: Laura Carter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT & ADDRESS: Mrs. Alice Curtis (wife) Hughesville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

356.

Immediate cause (a) Pulmonary infection — INTERVAL BETWEEN ONSET AND DEATH:

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b) DUE TO Amyotrophic lateral sclerosis — 7 mos
(c) DUE TO

II. OTHER SIGNIFICANT CONDITIONS:
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/21, 1952, to 12/18, 1952, that I last saw the deceased alive on 12/18, 1952, and that death occurred at 1:32 a.m., from the causes and on the date stated above.

SIGNATURE Roy Gaither, M.D. (DEGREE OR TITLE) ADDRESS Mechanicsville DATE SIGNED 1/29/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF 1/31/53
NAME OF CEMETERY OR CREMATORY: St. Marys Cemetery
LOCATION (City, town, or county) (State): Bryantown, Md.

DATE REC'D BY LOCAL REG. 1/29/53
REGISTRAR'S SIGNATURE: Julia H. Posey

24. FUNERAL DIRECTOR: Huntt & Ryon
ADDRESS: Waldorf, Md.

Item C FilmG150 2/2/53 MdW

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 100

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 3-51

1. PLACE OF DEATH:
COUNTY: Charles — MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town):
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Physicians Memorial Laplata Md

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Md — COUNTY: Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Grayton
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED: (Type or Print) (First) CECIL (Middle) E (Last) HENDERSON

4. DATE OF DEATH: (Month) 1 (Day) 24 (Year) 1953

5. SEX: M

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: 8-1-09

9. AGE last birthday: 43 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Charles Md

12. CITIZEN OF WHAT COUNTRY? U S Cit

13. FATHER'S NAME: Ernest N Henderson

14. MOTHER'S MAIDEN NAME: Lottie Monroe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT & ADDRESS: Mr Lottie Henderson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN ONSET AND DEATH: Nov 1952

593.4 Immediate cause (a) DUE TO: Nephritis

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b) DUE TO:
(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-2-53, 19..., to 1-24-53, 19..., that I last saw the deceased alive on 1-24-53, 19..., and that death occurred at 12:30 p.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS: E Fuller MD Laplata Md — DATE SIGNED: 1-24-53

23. BURIAL, CREMATION, REMOVAL (Specify): — DATE THEREOF: 1/26/53 — NAME OF CEMETERY OR CREMATORY: Mangonia Baptist — LOCATION (City, town, or county) (State): Mangonia Md

DATE REC'D BY LOCAL REG. 1/26/53 — REGISTRAR'S SIGNATURE: Jules H. Posey

24. FUNERAL DIRECTOR — ADDRESS: Hewitt & Rogers Waldorf Md

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

1142

Reg. Dist. No. 1 (20)

1. PLACE OF DEATH: COUNTY Charles — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bel Alton — LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY [illegible]
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Faulkner
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) [illegible] (Middle) (Last) [illegible]son

4. DATE OF DEATH: (Month) Jan. (Day) 2 (Year) 19[illegible]

5. SEX: M. — 6. COLOR OR RACE: Col. — 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M. — 8. DATE OF BIRTH: [illegible] — 9. AGE last birthday: [illegible] yrs. — If under 1 year: Months / Days — If under 24 hrs: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer — 10b. KIND OF BUSINESS OR INDUSTRY: General — 11. BIRTHPLACE (State or foreign country): Md. — 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: [illegible] Jackson — 14. MOTHER'S MAIDEN NAME: [illegible]

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No. — 16. SOCIAL SECURITY NO. — 17. INFORMANT AND ADDRESS: [illegible]

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

* **Immediate cause** (a) Fracture of cervical spine with laceration of spinal cord.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR? Struck by car

22. *I certify that I took charge of the remains described above, held an Autopsy ___, Inspection ✓ Inquiry ___ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ___, accident ✓, suicide ___, homicide ___, undetermined ___.*

SIGNATURE: Richard F. Daly — (Degree or title): M.D. — ADDRESS: La Plata, Md. — DATE SIGNED: 1/24/53

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE THEREOF: 1/26/53 — NAME OF CEMETERY OR CREMATORY: [illegible] — LOCATION (City, town, or county) (State): [illegible]

DATE REC'D BY LOCAL REG. 1/26/53 — REGISTRAR'S SIGNATURE: [illegible] — 24. FUNERAL DIRECTOR — ADDRESS: [illegible]

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 104

M

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Charles MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Victoria
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Victoria
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) MARTHA (Middle) (Last) REEDER

4. DATE OF DEATH: (Month) Jan. (Day) 26 (Year) 1953

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W.

8. DATE OF BIRTH: Nov. 17, 1854

9. AGE last birthday: 98 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hsw

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Edward Riordan

14. MOTHER'S MAIDEN NAME: Percea Popari

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: Foster Reeder, Mt. Victoria, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

			Interval Between Onset and Death
Immediate cause	(a)	Respiratory Failure	2 hrs.
DUE TO			
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b)	Cardio-vascular-renal disease	6 yrs.
DUE TO			
	(c)	Senil Arterial Sclerosis	10 yrs.

442X

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: **19b. MAJOR FINDINGS OF OPERATION:**

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M. INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1948, to Jan. 26, 1953, that I last saw the deceased alive on 26 Jan., 1953, and that death occurred at 4:30 A.m., from the causes and on the date stated above.

SIGNATURE S. Woodd (DEGREE OR TITLE) MD ADDRESS La Plata DATE SIGNED 26 Jan 53.

23. BURIAL, CREMATION REMOVAL (Specify): Burial DATE THEREOF 1/28/53 NAME OF CEMETERY OR CREMATORY Christ Church LOCATION (City, town, or county) Wayside, Md. (State)

DATE REC'D BY LOCAL REG. 1/28/53 REGISTRAR'S SIGNATURE William J. Rice **24. FUNERAL DIRECTOR** Huntt + Ryan, Waldorf, Md. ADDRESS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:

COUNTY: CHARLES — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: LA PLATA

LENGTH OF STAY (in this place): 6 DAYS

HOSPITAL OR INSTITUTION OR STREET ADDRESS: PHYSICIANS' MEMORIAL HOSPITAL LA PLATA, MARYLAND

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: MARYLAND — COUNTY: CHARLES

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: WALDORF (RURAL)

STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED: (Type or Print) (First) ANDREW (Middle) JEROME (Last) RICHARDSON

4. DATE OF DEATH: (Month) JANUARY (Day) 29 (Year) 1953

5. SEX: [redacted]MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: FEBRUARY 5, 1895

9. AGE last birthday: 57 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY: FARMING

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: WILLIAM RICHARDSON

14. MOTHER'S MAIDEN NAME: ELLEN BALL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT & ADDRESS: MRS. CATHERINE RICHARDSON: BRANDYWINE MARYLAND

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a)	ACUTE CORONARY THROMBOSIS	6 DAYS
	DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b)	CORONARY SCLEROSIS	4 YEARS
	DUE TO		
	(c)		

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE) —

TIME OF INJURY (Month) (Day) (Year) (Hour) — M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from SEPT., 1947, to JANUARY 29, 1953, that I last saw the deceased alive on JANUARY 28, 1953, and that death occurred at 5:30 A.m., from the causes and on the date stated above.

SIGNATURE: John H. Griffin (DEGREE OR TITLE) M.D. ADDRESS: HUGHESVILLE, MD. DATE SIGNED: 1/29/53

23. BURIAL, CREMATION REMOVAL, (Specify): Burial — DATE THEREOF: 2/1/53 — NAME OF CEMETERY OR CREMATORY: Emanuel — LOCATION (City, town, or county) (State): Baden, Md.

DATE REC'D BY LOCAL REG.: 1/29/53 — REGISTRAR'S SIGNATURE: Julia H. Posey

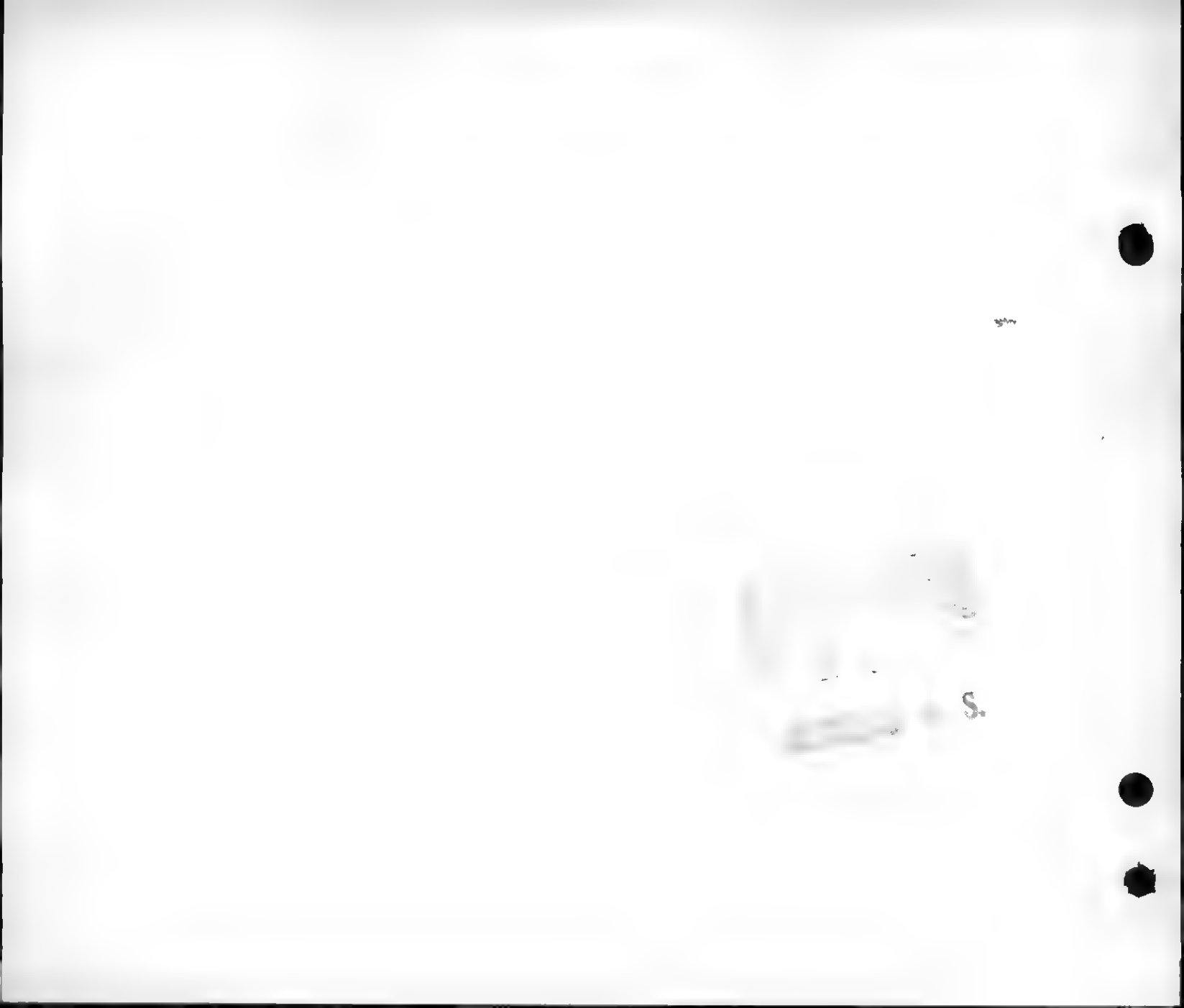
24. FUNERAL DIRECTOR ADDRESS: Hewitt & Ryan, Waldorf, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 [redacted]1

1



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 6-26

1. PLACE OF DEATH:

COUNTY Charles — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Indian Head

LENGTH OF STAY (In this place): 5 Years

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Charles

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Indian Head

STREET ADDRESS (If rural, give location) 8 Mattingly Ave

3. NAME OF DECEASED: (Type or Print) (First) Annie (Middle) Laura (Last) Senne

4. DATE OF DEATH: (Month) 1 (Day) 11 (Year) 1953

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	W	Widowed	Jan. 16, 1875	77 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Virginia	U. S. A.

13. FATHER'S NAME: Daniel Hall

14. MOTHER'S MAIDEN NAME: Sara Beach

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS: Emmaline S. McNair
No		8 Mattingly Ave. Indian Head, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

4341

Immediate cause (a) Cardiac Failure — DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) In firmities of Age, — DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH: Years

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY?
—	—	Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
—				

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from Jan., 19 47, to Jan 11, 1953, that I last saw the deceased alive on Jan 11, 19 53 and that death occurred at 5 P. M. from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) George E. Pickrell, M.D. ADDRESS Marbury Md DATE SIGNED Jan 11 1953

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1-14-53	Ft. Lincoln Cemetary	Prince George Co. Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1/15/53	Odey Price	S. N. Hines Co.	2901 14th St N.W. Washington D.C.

VS. A15 8-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH
COUNTY: CHARLES
STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: DONCASTER
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: HOME

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND
COUNTY: CHARLES
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Doncaster
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Lillie (Middle) Elizabeth (Last) SPEAKE

4. DATE OF DEATH: (Month) Jan. (Day) 22 (Year) 19[illegible]

5. SEX: F.

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M.

8. DATE OF BIRTH: 4-15-1876

9. AGE last birthday: 56 yrs. If under 1 year: Months / Days / If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Va.

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: William Brown

14. MOTHER'S MAIDEN NAME: Rosey Posey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: William Speake, Doncaster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) ACUTE CORONARY OCCLUSION	10 MINS.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) CORONARY ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	6 MOS.
	(c)	

4-10-1

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?:

22. I hereby certify that I attended the deceased from DEC 19, 1947, to JAN. 19, 1953, that I last saw the deceased alive on JAN. 19, 1953, and that death occurred at 11:45 p.m., from the causes and on the date stated above.

SIGNATURE: Harran Harbor (Degree or title) M.D. ADDRESS: La Plata, Maryland DATE SIGNED: 1-22-53 1-23-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | **DATE**: 1/25/53 | **NAME OF CEMETERY OR CREMATORY**: Monumental | **LOCATION** (City, town, or county) (State): Pomonkey, Md.

DATE REC'D BY LOCAL REG.: 1/25/53 | **REGISTRAR'S SIGNATURE**: 1/2-53 John H. Isaac | **24. FUNERAL DIRECTOR, ADDRESS**: Hewett & Ryon, Waldorf, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Charles — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN La Plata
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Physicians Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Tompkinsville
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Gertrude (Middle) (Last) Templeman

4. DATE OF DEATH: (Month) (Day) (Year) Jan. 27 19 53

5. SEX: F

6. COLOR OR RACE: C.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M.

8. DATE OF BIRTH: Jan. 15, 1906

9. AGE last birthday: 47 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Lewie Chapman

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: Michael Templeman, Tompkinsville, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral hemorrhage DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) DUE TO High Blood Pressure

331+

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. 0

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED 1-28-53

23. BURIAL, CREMATION REMOVAL. (Specify): Burial

DATE THEREOF 1/30/53

NAME OF CEMETERY OR CREMATORY Holy Ghost

LOCATION (City, town, or county) (State) Thompsonville Md

DATE REC'D BY LOCAL REG. 1/29/53

REGISTRAR'S SIGNATURE Julia H. Casey

24. FUNERAL DIRECTOR ADDRESS Arthur Ryon Waldorf Md

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH: COUNTY Charles MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN La Plata, Md. — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Wayside
HOSPITAL OR INSTITUTION OR STREET ADDRESS Physicians Memorial Hospital	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	(First) Mary	(Middle) Genevieve	(Last) Thomas	4. DATE OF DEATH	(Month) January	(Day) 2	(Year) 1953
5. SEX Female	6. COLOR OR RACE Colored	7. ~~SINGLE, MARRIED, WIDOWED, DIVORCED~~ (Specify)	8. DATE OF BIRTH Feb 8, 1916	9. AGE last birthday 36 yrs.	If under 1 year Months. Days	If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (State or foreign country) Charles Co Md	12. CITIZEN OF WHAT COUNTRY? U.S.				
13. FATHER'S NAME John Ford	14. MOTHER'S MAIDEN NAME Nellie Smallwood						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS Eugene Thomas - Wayside, Maryland					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Respiratory collapse — 1 min

Antecedent cause(s) (b) Cerebral vascular accident — 2 hours

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

331X

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —	19b. MAJOR FINDINGS OF OPERATION —	20. AUTOPSY? Yes ☐ No ☑
21. ACCIDENT SUICIDE HOMICIDE (Specify) —	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19....., to 2 Jan, 1953, that I last saw the deceased alive on 2 Jan, 1953, and that death occurred at 8:45 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
S B Woodey	MD	La Plata Md.	2 Jan 53.

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 1/6/53	NAME OF CEMETERY OR CREMATORY Holy Ghost	LOCATION (City, town, or county) Issue Md (State)
DATE REC'D BY LOCAL REG. 1/5/53	REGISTRAR'S SIGNATURE Julia H. Posey	24. FUNERAL DIRECTOR Hunt & Ryon	ADDRESS Waldorf Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 7 19[illegible]
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 004285

CERTIFICATE OF DEATH

Reg. Dist. No. 105

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

1. PLACE OF DEATH:

COUNTY Charles — MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Pomfret

LENGTH OF STAY (in this place) 9 Yrs.

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Charles

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pomfret

STREET ADDRESS (If rural, give location) None

3. NAME OF DECEASED: (Type or Print) (First) Elizabeth (Middle) Swann (Last) Thompson

4. DATE OF DEATH: (Month) (Day) (Year) 1-14-53 19

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	Negro	Widow	12-25-1860	92 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: William Henry Swann

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Walter Thompson (Son)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myocarditis Chronic — DUE TO — Indefinite

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) Senility — DUE TO — Indefinite

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from 1-11-53, 19 1-14-53, 19....., that I last saw the deceased alive on 1-14-53, 19....., and that death occurred at 10 AM m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS — DATE SIGNED

Jan 28 Chas. A. Mc Millan M D Med Dr 1-16-53

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1/17/53	St Thomas	Bidalton Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1-23-53	W. L. Mowell	Heath & Ryon	Waldorf Md

RECEIVED
JAN 26 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00429

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH COUNTY: CHARLES MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: MARYLAND COUNTY: CHARLES
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: BENEDICT — LENGTH OF STAY (in this place): 70 YEARS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: BENEDICT
HOSPITAL OR INSTITUTION OR STREET ADDRESS: —	STREET ADDRESS: — (If rural, give location)

3. NAME OF DECEASED (Type or Print)	(First) FREDERICK	(Middle) MILEY	(Last) TOYE	4. DATE OF DEATH	(Month) JANUARY (Day) 11 (Year) 1953
5. SEX: MALE	6. COLOR OR RACE: NEGRO-U.S.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH: JULY 5, 1861	9. AGE last birthday: 91 yrs.	If under 1 year: Months. Days; If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): WATERMAN	10b. KIND OF BUSINESS OR INDUSTRY: OYSTERING AND FISHING	11. BIRTHPLACE (State or foreign country): CALVERT CO., MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME: DAVID TOYE	14. MOTHER'S MAIDEN NAME: HARRIET ANNE EDELEN				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If year, give war or dates of service) —	16. SOCIAL SECURITY No.: NONE	17. INFORMANT AND ADDRESS: MARY BELL; BENEDICT, MARYLAND.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.0

Immediate cause (a) ARTERIO-SCLEROTIC HEART DISEASE — 4 YEARS

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) GENERALIZED ARTERIO-SCLEROSIS — ?20 YEARS

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —	19b. MAJOR FINDINGS OF OPERATION: —	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify) —	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	(CITY OR TOWN) — (COUNTY) — (STATE) —
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from SEPTEMBER 1949, to JANUARY 11, 1953, that I last saw the deceased alive on January 11, 1953, and that death occurred at 9 30 A.M., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
John H. Griffin	M.D.	Hughesville, Md.	1/11/53

23. BURIAL, CREMATION REMOVAL (Specify)	DATE: 1-14-53	NAME OF CEMETERY OR CREMATORY: St Peters	LOCATION (City, town, or county) (State): Waldorf Md
DATE REC'D BY LOCAL REG.: 1/12/53	REGISTRAR'S SIGNATURE: Julia H. Pasey	24. FUNERAL DIRECTOR: Hunt & Ryan	ADDRESS: Waldorf Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1

RECEIVED
JAN 14 1953
BUREAU V. S.